MDR Tracking Number: M5-04-1733-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 02-13-04.

The IRO reviewed therapeutic activities and therapeutic exercises rendered from 06-10-03 through 06-12-03 and 06-23-03 through 06-24-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 04-21-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97530 (16 units) dates of service 06-02-03 through 06-20-03 denied with denial code "R" (extent of injury). No TWCC-21 had been filed by the respondent. The services are reviewed per the 96 Medical Fee Guideline. Per MEDICINE GR I(c) reimbursement in the amount of $560.00 ($35.00 X 16 units) is recommended.

CPT code 97110 dates of service 06-02-03 through 06-20-03 denied with denial code "R" (extent of injury). No TWCC-21 had been filed by the respondent. The services are reviewed per the 96 Medical Fee Guideline. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule

133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 06-02-03 through 06-20-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 27th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

October 7, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected dates of service in dispute.

Re: Medical Dispute Resolution
MDR #: M5-04-1733-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
Correspondence
H&P and office notes
Physical therapy notes
FCE/Nerve Conduction Studies
Radiology reports

Clinical History:
Patient received physical medicine treatments after injuring lumbar and cervical spine as a result of an on-the-job accident on ___.

Disputed Services:
Therapeutic activities and therapeutic exercises during the period of 06/10/03 through 06/12/03 and 6/23/03 through 06/24/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the therapeutic activities and exercises in dispute were not medically necessary in this case.

Rationale:
Insufficient documentation was supplied to determine if the treatment in question was different from the 8 weeks of preceding care that was non-beneficial (reported in the review dated 02/27/04) or just a continuation of the same unsuccessful care. Absent documentation that this treatment was different, it was medically unnecessary.

Moreover, the records fail to document that spinal manipulation (as opposed to "joint mobilization" of the sacrum) was ever performed. According to the AHCPR[1] Guidelines, spinal manipulation is the only treatment that can relieve symptoms, increase function and hasten recovery for adults with acute low back pain. Other studies have shown the similar benefits of spinal manipulation for cervical spine conditions. Based on those findings, it is unclear as to why the doctor performed a host of non-recommended therapies rather than a proper regimen of spinal manipulation, which is the recommended and clearly indicated form of care for the patient's condition. Therefore, if spinal manipulation had not been performed previously, the patient's reported lack of response is not surprising since the type of treatment most likely to have benefited the patient was not provided.

Sincerely,

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[1] Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.